A STUDY OF THE EFFECTIVENESS OF TREATMENT METHODOLOGIES WITH INTRAVENOUS DRUG ABUSERS INFECTED WITH THE AIDS VIRUS

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

SANDRA GOODMAN

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JULY 1988

ABSTRACT

SOCIAL WORK

GOODMAN, SANDRA LeMoyne Owen College, 1984

A STUDY OF THE EFFECTIVENESS OF TREATMENT METHODOLOGIES WITH INTRAVENOUS DRUG ABUSERS INFECTED WITH THE AIDS VIRUS

Advisor: Dr. Jacqueline Everette Brown

Thesis dated July, 1988

The purpose of this study was to determine the relationship between selected treatment methods, i.e., individual counseling and support groups, and the ability of intravenous drug users with AIDS to stop using drugs. A cross-ectional survey design, using clients at AID Atlanta and Augusta Correctional Medical Institute, was employed in the study. The data were collected using a mailed questionnaire developed by AID Atlanta and the researcher. Data were analyzed using descriptive statistics and are reported in terms of frequency and percentage. The Phi (Ø) test was also used to determine the strength of the relationship between individual counseling and support groups and the ability to stop using drugs. The null

hypotheses proposed that there is no significant relationship between individual counseling and support groups and the ability to stop drug use.

The results indicated that there is a strong relationship between the two treatment methods and the ability of intravenous drug users with AIDS to curtail their use of drugs. The Phi (Ø) coefficient for individual counseling and the ability to stop using drugs was Phi is equal to .827 and the coefficient for support groups and the ability to stop using drugs was Phi is equal to .786.

ACKNOWLEDGEMENTS

The author wishes to give thanks to GOD for guidance and strength in the completion of my graduate studies and thesis. Also, I wish to thank my parents, Prentis and Bessie Goodman and my sisters and brothers: Rhonda, Carolyn, Adrianne, Prentis Jr., Tracey, and Stacey for their undying patience and love. Sincere appreciation goes to AID Atlanta (Special thanks to the Social Service Department), the clients of AID Atlanta, and the inmates at Augusta Correctional Medical Institution for their cooperation in the completion of my research. And last, special thanks goes to my mentors, Dr. Jacqueline Everette Brown, my thesis advisor and Doris Taggart Thomas, a dear friend, for their motivational encouragement and belief in me; and Dr. Amos Ajo for his help in the completion of my methodology and statistics.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

The problem that stimulated this study is what is considered to be the most deadly epidemic of the 1980s, the AIDS virus. This study focused on the second largest population of persons with AIDS, the intravenous (IV) drug user. This study examined two treatment methods utilized with this population, individual counseling and support groups, to determine their effectiveness in the attempt to help IV drug users with the AIDS virus curtail their use of drugs.

AIDS (Acquired Immune Deficiency Syndrome) is a virus which affects the body's immune system, and it is usually diagnosed when a person's body is unable to fight infection. The largest majority of people who have been affected with this deadly virus are homosexual and bisexual men who are, or have been in the past, sexually active. The second largest group to have developed the AIDS virus are intravenous drug users. Intravenous (IV) drug use is a risk factor. Of 27,843 adult cases of AIDS reported to the Center for Disease Control (CDC), 6,948 listed IV drugs as their primary risk factor. Of

these, 2,188 also had male homosexual behavior as a risk behavior. (Center for Disease Control, 1986).

AIDS is a disease which can have devastating psychological results. The reasons are numerous. According to the U.S. Department of Health and Human Services:

- Seventy percent of all people with AIDS die within two years.
- To date, all but a small minority of AIDS patients are homosexual and bisexual men, or intravenous drug abusers - individuals who already may be stigmatized and subject to social and job-related discrimination. Such problems multiply with a diagnosis of AIDS.
- Ninety percent of all adults with AIDS are in the prime of life - between the ages of 20 and 49 - when people are not commonly prepared to deal psychologically with imminent death.
- The infections and malignancies that accompany AIDS can diminish and disfigure the body.

- The AIDS virus often attacks the central nervous system, causing symptoms ranging from forgetfulness to profound dementia.
- The course of AIDS is marked by a series of life threatening episodes, such as infection with pneumocystic carinii pneumonia.
- Few other diseases produce as many losses; loss of physical strength, mental activity, ability to work, self-sufficiency, social roles, income and savings, housing, and the emotional support of loved ones. Often, self-esteem also fades in the wake of such catastrophic losses.
- The physical weakness and pain resulting from AIDS - related diseases diminish the patient's ability to cope with psychological and social stress.
- Treatment for AIDS-related diseases, which may palliate, but do not cure, may themselves cause psychological problems such as listlessness, depression, and anxiety.

Living with the threat of AIDS can be devastating. For those who have developed symptoms affiliated with AIDS, the uncertainty of not knowing, can be more stressful than for those people who have been diagnosed with the virus. Individuals who have no symptoms, but know they have been infected with the virus, suffer to the point that they are immobilized by fear. Those individuals who practice or in the past have practiced high risk behavior have to face the death of friends and loved ones, the public fear of AIDS, and the ostracism from employers and insurance companies.

Health care professionals who treat people with AIDS (PWA's) acknowledge that the disease has an emotional effect along with a physical one. Sometimes psychological symptoms accompany brain infections, while other symptoms are the reactions of patients who know they are facing death. (U.S. Department of Health and Human Services, p. 4).

Recently, it has become apparent that, in addition to psychological reactions and organic brain conditions resulting from opportunistic infections, some people with AIDS show symptoms of other types of neurological damage. The HIV virus infects some cells in the brain. Postmortem analysis and neuropsychiatric

evaluation of patients with various stages of the HIV virus demonstrates that central nervous system involvement may be extensive in some patients. Some symptoms that appear to be psychologically caused may in fact be organic in origin and degenerative in course. (U.S. Department of Health and Human Services, p. 5).

Infection with the AIDS virus causes extreme problems not only for people with a diagnosis of AIDS, but also for those who have other stages of infection. The onset of symptoms swollen lymph nodes, continuous infections, fatigue, and weight loss is often accompanied by the fear of developing AIDS. If and when a diagnosis of AIDS is given, it will bring relief in some and psychological symptoms in others. (U.S. Department of Health and Human Services, p. 5).

Anxiety and depression are most common. Distress is evident in the preoccupation with illness and imminent death, characteristic of patients with cancer and other often-fatal diseases. (U.S. Department of Health and Human Services, p. 5). The stress response at the time of diagnosis may be marked by disbelief, numbness, and the inability to fact facts. PWAS are angry at the disease, at the discrimination that usually

accompanies it, at medical staff, and at themselves. Those who see themselves as "innocent victims" of the virus, having contracted it, for example, from a blood transfusion, are particularly prone to anger. (McKusick, 1986).

In many cases, unfound guilt develops with the diagnosis of the AIDS virus. Guilt about past behaviors, style of living, and an extreme sense of liability having transmitted it to others will cause PWAS to exhibit sadness, hopelessness, helplessness, withdrawal, isolation, and other symptoms associated with depression. Anticipating the physical and mental affects that will occur, many PWAS contemplate suicide, but few are successful.

Because both social and physical assistance are needed, a strong network of friends and family is particularly important. Homosexuals and I.V. drug users who are alienated from their families may lack any kind of support. Severe strain is also created for persons whose gay lifestyle, or drug addiction becomes known when AIDS is diagnosed.

Men and women who habitually use drugs are harder to reach and adequately educate about the AIDS virus than others who have participated in high risk behavior.

Homosexuals, whom the AIDS virus has affected the hardest so far, can be reached and educated at bars, nightclubs, bathhouses, and gay organizations. But the I.V. drug users, who frequent "shooting galleries" are usually in a drug-induced haze and seem to comprehend little about fighting the spread of the deadly virus. In New York City, I.V. drug users are the apparent source of the virus in 87 percent of the cases in which heterosexual activity is believed to be the mode of transmission, and in 80 percent of the cases of maternally transmitted AIDS. (New York City Department of Health, 1986).

It is unreasonable and unsafe to literally let society forget about these "undesirables" who many feel will just be a product of their own self destruction. What many fail to understand is that these people who abuse IV drugs go home to their wives, husbands, boyfriends and girlfriends, and inadvertently, transmit the deadly virus. It is now a major controversial issue on whether clean needles should be dispensed to IV drug users in the shooting galleries and in local areas that are infected with the abundant selling of drugs. (AIDS Alert, pp. 103-104). Whether or not the different cities and communities agree or disagree with this idea,

we must address this issue to city and state governments and legislatures that this is a major concern, and without educating the drug users, however, futile it may seem, will eventually lead to the demise of a society.

The cost of health care for PWAS is extremely expensive. IV drug abusers have a more difficult time receiving health care treatment once they are diagnosed. Almost none have life insurance; they have poor health; they tend to delay getting treatment when they need it; and they have a higher mortality rate than homosexuals. (Health Link, June 1986). After an AIDS diagnosis, PWAS then realize that their abusive behavior has resulted in their contracting a terminal illness. When a social worker meets an IV drug user with AIDS in the initial intake session, in their plea to receive counseling, many addicts will admit their life has no meaning, and they have hit rock bottom. The treatment methods utilized by social workers in helping a person with AIDS usually will consist of individual counseling, support group participation, and educational resources. The treatment methodologies used for IV drug abusers consist of the same approaches even though the abuser is facing

two dilemmas; a terminal illness and the need to moderate or completely cease the use of IV drugs.

In an effort to live a clean and drug free life until death, some addicts will request treatment from a detoxification program to help eliminate their use of drugs. While some IV drug users will attempt to receive treatment others in the denial stage will admit to the social worker that they will continue to use IV drugs in an effort to deny the reality of their inevitable suffering and eventual death.

Purpose

The purpose of this study was to examine the effectiveness of treatment methods employed with IV drug users with the AIDS virus. The independent variable was the treatment methodologies utilized which included individual counseling and support groups. The dependent variable was the IV drug users ability to discontinue drug use as a result of treatment.

AIDS is a relatively new virus that has made an explosive impact in today's society. The treatment methods, for people with AIDS (PWAs) without a substance abuse problem have been emotionally draining for health care professionals who provide services to

this special population; because of the prejudices expressed by friends and relatives, the moral and ethical issues, and the ignorance of the general public.

With a disease so widely misunderstood, social workers and other service oriented profressionals have recently devised treatment methodologies specifically for PWAS who have a substance abuse problem. This includes individual counseling sessions and support group participation.

The individual counseling includes indepth psychotherapy (the amount or frequency depends on the emotional status of the PWA upon assessment), and emotional counseling. Support groups include the interaction and participation (in a group setting) of PWA's who are experiencing the same problems. This group can provide emotional support as well.

With this knowledge, effective treatment methods must be continuously identified and implemented to successfully provide treatment to this population.

With the AIDS epidemic on the rise, it is very difficult to visit any major U.S. city and not find an AIDS information hotline. These services are designed to educate the general population anonymously, to

answer questions pertaining to the transmission of the virus, symptoms, and testing sites.

This study examined treatment methods (other than those already implemented for PWAS without a substance abuse problem) for IV drug users with AIDS. Some issues raised are:

1. Since a diagnosis of AIDS, has the client stopped using drugs?
2. Has the client enrolled in a rehabilitation center, or joined a support group since diagnosis?
3. What type of treatment is the client receiving now?
4. What type of treatment is needed to maintain a meaningful quality of life for the time remaining?
5. Are there similar and/or different plans needed for a PWA and a PWA who also has an IV drug use problem?

This research focused on the IV drug user with AIDS and the preventive strategies used in treatment with this growing population.

CHAPTER II

REVIEW OF THE LITERATURE

Development of the AIDS Epidemic

AIDS is a widely misunderstood disease. Educating the general public on the transmission of the disease is and will be an on-going occupation. Not since the black plague of the 1930s, has a society panicked and overtly displayed discrimination toward people afflicted with a terminal illness. This review of related literature begins with the development of the AIDS epidemic, and traces its course. It also examines the epidemiology of AIDS, and concludes with a prediction of how this disease will affect society in the future.

The Acquired Immune Deficiency Syndrome, or AIDS, was first reported in the United States in mid-1981. Since that time, the Public Health Service has received reports of more than 15,000 cases, about 52 percent of which have resulted in death. An estimated 500,000 to 1.5 million people have been infected by the virus that causes AIDS, but have no symptoms of the illness. (United States Department of Health and Human Services, 1984). AIDS comes as a result of a defect in the immune

system. This defect causes the body to be unable to fight diseases. People who have AIDS are more susceptible to serious illnesses which would not be a threat to anyone whose system is functioning normally. These illnesses are referred to as "opportunistic infections" or diseases. (United States Department of Health and Human Services, 1984, Winter).

AIDS is transmitted by sexual contact, needle sharing, or through blood transfusions or its components. The risk of contracting the virus is increased by having multiple sexual partners, (either homosexual or heterosexual), and sharing needles by using IV drugs. Hemophilia patients or people receiving blood transfusions and thereby contracting the AIDS virus, give evidence that the viris is found in blood products. It may be transmitted from infected mother to infant before, during, or shortly after birth. (United States Department of Health and Human Services, 1986, Winter).

On the basis of studies of AIDS cases in the United States since 1981, the Public Health Service has identified certain groups in the population that are at increased risk for infection with the AIDS virus. (American Red Cross, United States Public Health Service, 1986, October). If a person is having multiple sexual

partners, they are increasing their chances of contracting the AIDS virus. If a person is healthy and had not participated in any high risk behaviors, the best chance for avoiding AIDS is a monogamous sexual relationship with a person whose sexual history is well known.

Persons in the following groups are at increased risk of infection by the AIDS virus:

- Homosexual and bisexual men (or men who have had sex with another man since 1977).
- People who inject illegal IV drugs or who have done so in the past.
- Persons with symptoms of AIDS or AIDS related complex.
- Persons from Haiti and Central African countries, where heterosexual transmission is thought to be more common than in the United States.
- Male or female prostitutes and their sexual partners.
- Sex partners or persons infected with the AIDS virus or at increased risk of infection.
- Persons with hemophilia who have received clotting factor products.

- Infants of high risk or infected mothers.

(American Red Cross, Public Health Service, 1986, October).

As of February 23, 1987, AIDS had been diagnosed in 31,036 people in the United States and had claimed 17,851 lives, according to the Centers for Disease Control. The Centers estimate that one million to 1.5 million Americans have been infected with the AIDS virus and that 30 to 50 percent of that total will develop AIDS by the end of 1991. (New York Times, 6 March 1987).

Within the next five years, a dramatic increase in the incidence of AIDS is anticipated, which will require a widespread case management system that has yet to be designed. (Catlin, 1987). The nature of the disease requires the implementation of care facilities, community care facilities, and services that would offer care to meet the needs of patients and to reduce the cost of hospitalization.

At the Coolfront Conference in June 1986, 85 representatives of the United States Public Health Service (USPHS) and AIDS Service programs estimated that by 1991, 145,000 individuals with AIDS will require medical care. (Coolfront Report, 1986, July-August). During that year, an additional 74,000 new cases will be

diagnosed and 54,000 people will die. By the end of 1991, they anticipate that 270,000 cumulative cases of AIDS will have been reported.

An increase in the number of heterosexually transmitted cases has been anticipated. Cases of heterosexual transmission now account for 7 percent of all cases, or approximately 1,100 reported cases. By 1991, this figure is projected to increase to 9 percent of the total of 7,000 cases. In addition, by 1991, the number of children with AIDS, it is predicted, will be ten times the current reported figure of 3,000. By 1991, it is predicted that more than 80 percent of the cases will be reported from outside New York and San Francisco. (Coolfront Report, 1986, July-August). With these predictions, AIDS will not primarily exist in urban areas, but in rural areas as well.

Symptoms

The AIDS case definition was revised effective September 1, 1987, to include severe HIV diseases not previously considered AIDS. This revision will increase the number of officially reported AIDS cases by approximately 15 percent. (The Harris County Medical Society & Houston Academy of Medicine, 1987, p. 13). A person has AIDS if he or she has certain immune system

problems and one of the following conditions: kaposi's sarcoma, pneumocystis carinii pneumonia, or a Center for Disease Control definition of infections and conditions.

There are some symptoms which are common in most people who get the AIDS virus. These people may experience some or all of the following:

- Unexplained, persistant fatigue.
- Unexplained fever, night sweats, or shaking chills that last for several weeks or more.
- Sudden and unexplained weight loss of ten pounds or more.
- Diarrhea that continues for several weeks.
- A dry cough that will not go away.
- Purple or pink spots on or under the skin, inside the mouth, nose, or around the eyes. These spots are generally harder than the skin around them.
- White spots around or in the mouth that lasts for weeks. (The Harris County Medical Society & the Houston Academy of Medicine, 1987, p. 13).

Testing of the AIDS Virus

There are some people who test negative and still carry the AIDS virus in their blood. It takes anywhere

from two weeks to six months after exposure, for the body to produce the AIDS antibodies.

The current tests used to diagnose the AIDS virus do not detect AIDS; they detect the antibodies in the blood. These antibodies usually means that a person has been infected with the virus. However, these tests cannot tell whether or not that person will develop AIDS or other related HIV symptoms in the future.

The most widely used test, the ELISA, is the easiest and cheapest to use. The other major test, the Western Blot, or immunoblot, is a difficult, lengthy, and expensive procedure. The ELISA is very sensitive; it identifies almost all blood containing antibodies to HIV (the positives). The test is not so specific, however. It sometimes produces false positives; that is, positive readings on blood that does not contain antibodies to HIV. Thus, the ELISA alone is not valid for screening individuals. (Population Report, 1986, July-August).

The Western Blot, on the other hand, is highly specific, and false positives are rare. The Western Blot is recommended by the U.S. Public Health Service and the World Health Organizations to confirm a positive ELISA. It can be technically difficult, however, to interpret

Western Blot tests and results may vary among laboratories. (Population Reports, 1986, July-August).

Studies show that between 6 and 10 percent of people who have confirmed HTLV-III antibody go on to develop AIDS, usually within two years. Another 20 to 25 percent develop a range of illnesses called AIDS related complex (ARC). Approximately two thirds of persons positive for HTLV-III have never developed overt illness. (Population Reports, 1986, July-August). However accurate testing may be, if someone tests positive for the virus, but does not have AIDS, they can still pass the virus onto others. And if someone tests negative for the virus, they are still not safe, especially if they are in a high risk group.

Myths

The myth that AIDS is a gay white male disease is particularly fallacious when we talk about substance abuse and AIDS.

Faltz & Madover found that, "Half of the IV users with AIDS are black, more than a quarter are hispanic, and fewer than 20 percent are caucasian. More than half of the women with AIDS are IV drug users." (1987, p. 53). As we explore the dependent variable, the IV drug users with AIDS, research shows that this growing

population of people with AIDS (PWA's) will put the myth that AIDS is a gay white male disease to rest.

According to the New York City Health Commissioner, Stephan Joseph, "More than half of New York's 200,000 drug addicts are infected with the deadly virus. As many as 70 percent of those infected will develop AIDS or AIDS-related complex within five years." (New York Daily News, 11 October 1987).

Almost everyone believes AIDS has destroyed the immune systems of previously healthy people. Research shows that AIDS has struck people whose immune systems were already damaged. The known case of such damage in many AIDS patients has been drug abuse.

It appears that HTLV-III will produce AIDS only if the immune system is already damaged. Such pre-existing immune damage may result from congential deficiency, repeated transfusion of blood products, serious illness, poor environment or self-destructive conduct like drug abuse. (The Wall Street Journal, 21 October 1985).

It seems that PWA's have not been healthy people who contracted AIDS simply because they had sex with the wrong person. Rather, it seems to affect people who already were sick in the sense of having a damaged immune system. Apparently most were sick because they

abused drugs; which implies that some of today's abusers probably will be most of tomorrow's AIDS patients.

Substance Abuse and Aids

According to the Centers for Disease Control (CDC), intravenous (IV) drug abusers comprise the second largest population group at risk for AIDS in the United States. (Centers for Disease Control, 1985). National statistics compiled by the CDC show IV drug abusers to be 17 percent of diagnosed cases of AIDS. (The Wall Street Journal, 1985). Because of the widespread infection in homosexuals, most heterosexuals, the heterosexual community at large, and some health care professionals feel drug abusers are the forgotten people with AIDS.

Faltz and Madover state that often substance abuse is viewed as a weakness or a choice, not a disease. (Faltz & Madover, 1980). However, further research indicates this concept is untrue. According to Johnson, Faltz and Madover, "substance abuse is a disease characterized by the inability of a person to control the amount of frequency of alcohol or drug use. (Faltz & Madover, 1980). It involves the whole person, physically, mentally, psychologically, and spiritually. The most

significant characteristics of the disease are that it is primary progressive, chronic, and fatal. (Johnson, 1980).

According to the CDC, IV use is the primary risk factor for 17 percent of persons with AIDS. In addition, 11 percent of the gay and bisexual men report a history of IV drug use, making a total of 28 percent of those with AIDS IV drug users. (Center for Disease Control, 1985). The transmission of this virus is often spread through the sharing of hypodemic needles, syringes, and paraphernalia used in "shooting up" drugs.

Substance abusers with AIDS often will transmit the virus to their sexual partners, either through homosexual or heterosexual contact. The CDC states that of those reported cases of heterosexual transmission of the disease in the United States, the overwhelming majority have been women. (CDC, 1985).

Research shows that the abuse of drugs and alcohol will break down a person's immune system. Alcohol, marijuana, cocaine, and amphetamines have been demonstrated to be immuno suppressants. With the constant use and abuse of these drugs, studies have shown that through this abuse one's body is more susceptible to viruses. Faltz and Madover states that,

"Persons who have been exposed to the AIDS virus by their sexual partners or through IV drug use, need to re-examine their use of immunosuppressant drugs, particularly their use of poppers (volatile amyl and butyl nitrates). (Faltz & Madover, 1986).

Further research indicates that there is increased sexual and drug sharing behavior while under the influece of alcohol or drugs. In a report prepared for the San Francisco AIDS Foundation, the Research and Decisions Corporation (1985) cited the following findings:

> The results suggest that there is a significant problem with drug use among the city's self identifying gay and bisexual male population and that this problem may be perpetrating the AIDS epidemic. When asked if they were ever high or drunk while having sex, nearly one in five (18 percent) say they are at least so intoxicated that they would not want to drive a car. Fourteen percent say that they have used IV drugs at some point in their lives. Just 3 percent report doing so in the past six months, but this 3 percent accounts for 38 percent of all anal intercourse and 48 percent of all fisting with non-primary

> partners. This strong association between IV drug use and these unsafe sex practices suggest that the AIDS education issue cannot be separated from the larger issue of drug abuse. (p. 38).

In addition, the report noted the significant finding that 61 percent agree that they are more likely to have unsafe sex when using alcohol or drugs. (San Francisco AIDS Foundation, Research and Design, 1985).

Since there are so many physical, emotional, financial, and legal concerns associated with AIDS, often substance abuse problems are not seen as a priority to be addressed as some other needs. There is hope, however, that it can be treated with a continuing recovery program such as alcoholics anonymous or narcotics anonymous. If it is viewed as a question of morality or "will power" treatment will be aborted and the addiction process will progress. (Faltz & Madover, 1986).

Costs of Care

Estimated medical care for the treatment of people with AIDS has been projected to be very expensive. There have been several conferences held addressing this issue. At the Coolfront Conference, the United States

Public Health Service representatives conservatively estimated that direct care cost for AIDS patients would reach eight to sixteen million dollars by 1991, representing 1.2 - 2.4 percent of the total expenditures for personal health care in the United States. (Coolfront Report, 1986). It should be noted these figures however, are a conservative estimate. These figures could be underestimated by 10-50 percent because of the increased need for care of the large population of patients with other AIDS-related conditions and the significant non-medical costs of managing these illnesses. The cost of direct medical expenditure for the first 10,000 cases has been estimated at $1.4 billion. (Coolfront Report, 1986). It would be impossible with these predictions not to have a definite plan in providing medical care for the people who will contract the virus. Not only will medical care include weekly to monthly doctor and clinic visits; it will also include extensive hospital care.

Hospital care for AIDS patients is, on the average, 60-70 percent higher than for all other patients. (Catlin, 1987). With a disease so new and still somewhat in the experimental stages regarding medical care and a cure, it will require many PWA's to be hospitalized

whenever an opportunistic infection arises. According to Hultzman, "AIDS patients require two to three times more care from nursing staff than do other patients and that their need for psychological support is greater." (Hultzman, 1986). This statement proves that not only will doctors and nurses stamina be tested, but social workers, psychologists, psychiatrists, and other counselors as well.

Currently, if a person contracts the AIDS virus and is not medically insured, he or she will receive the medical treatment at a public health facility. Even with medicaid it is somewhat difficult to obtain medical treatment for a private physician and hospital. According to Catlin (1986):

> As the number of indigent and uninsured patients with AIDS increases, as it surely will, the amount of revenue lost in treatment of the average AIDS patient will threaten the quality of care these patients can receive within a profit-driven health care system. (p. 26).

It must be noted that indigent clients cannot pay their medical bills; the responsibility is placed on the taxpayers. It is especially a burden for taxpayers if the patient is hospitalized for prolonged periods.

Hultzman states that, "Outside the hospital setting, reimbursement is poor for long-term care, including hospices, although they are the most effective, cost efficient, and humane service for dying AIDS patients. (Hultzman, 1986).

With an estimation of so many people being hospitalized, suggestions have been made to separate PWA's. This separation will allow more concentration and the utilization of experts trained in treating infectious diseases. In Wallace's article in Modern Healthcare (1985), she states that:

> Hospitals must weigh the pros and cons of separating AIDS patients in specialized units where staff are trained to treat disease. She elaborates by saying these units allow the hospitals and staff to centralize resources and to develop expertise on AIDS. But not all hospitals have the space to open a special unit or their health care professionals do not believe it is appropriate to isolate the AIDS patient. (p. 56).

There have been additional resources such as McLaughlin, who agrees with Wallace. He states, "Some physicians contend that by segregating AIDS patients, hospitals are

neglecting their emotional needs." (McLaughlin, 1986). Whatever the case or situation may be, health care professionals will be able to anticipate an increase in the number of hospitalized people with the AIDS virus.

William Johnson, Chief Executive Officer at the University of New Mexico states that, "Community hospitals must also prepare for an increasing number of patients. Public hospitals will be deluged by thousands of new AIDS cases in the next five years, and must share the burden with community facilities." (Greene, 1987). In an effort to work more closely together, hospitals, both private and public must be willing to offer the best services available. While community hospitals can't provide services as comprehensive as those of large public facilities, they can coordinate efforts among psychiatrist, social workers, nutritionists, and other specialists to care for AIDS patients. (Greene, 1987).

To be hospitalized for an extensive period can be very traumatic for the patient; especially if diagnosed with a terminal illness. Some hospitals are now addressing both the AIDS patient and the employees of the hospital. According to Goldberg, the chief officer of Sherman Oaks Community Hospital, " treating an AIDS patient can be very devastating

psychologically for the health professional. (Modern Health Care, 1986). Experts agree that the hospital must provide psychosocial counseling for both patients and employees.

In addition to counseling, employee education is one of the first steps a hospital should take in preparing to treat AIDS patients. According to Arthur Sponseller, vice president of human resources at the Hospital Council of Southern California, Los Angeles, "If you educate employees about AIDS before they read on a patient's chart that the person has AIDS, you will head off the emotional reaction that is almost inevitable." (Modern Health Care, 1986).

A study done by John Hopkins University showed that many health workers are poorly informed and very anxious about AIDS. A 1985 U.S. study found that more than half of 1,200 health workers in an urban hospital wrongly thought that the virus could be transmitted by a sneeze. Some 25 percent sometimes avoided public places for fear of contracting AIDS. An equal percentage admitted extreme anxiety about working with AIDS patients. Health workers in other U.S. hospitals and in Africa also reported to be very concerned about treating people with AIDS, and in some cases they have refused to do so.

(Population Reports, 1986). If we attempt to provide education in the U.S. and other countries, health care professionals will hopefully provide the best care available to assist in the medical care of PWA's.

Education programs for health workers are underway in many countries. In the U.S., local AIDS organizations have given in service training to health workers in hospitals and extended care facilities and have prepared pamphlets for health care providers. The American Medical Association is conducting seminars for physicians in medical and health care aspects of AIDS, controversies over antibody screening and financial consequences. (Population Reports, 1986).

Individual Counseling and Support Groups

Since AIDS is a relatively new epidemic, the issue has been raised by many health care professionals concerning the most appropriate and effective way of providing support to people with AIDS. The most prevalent methods of intervention includes individual counseling which consists of the person with AIDS in a one-on-one session with a therapist; and support groups which includes a therapist and several individuals who have been infected by the AIDS virus.

Lopez and Getzel describe AIDS as a condition that exposes a patient to an array of catastrophic diseases of indeterminate duration which may be incapacitating or fatal. (Lopez & Getzel, 1984). They elaborate by saying in most cases, the worker is concerned about the psychosocial condition of a person with AIDS as he or she suffers a rapid succession of emotional reactions best described as "a rollercoaster ride."

During an initial visit to a social worker, the PWA is usually in a crisis situation. However, Getzel and Lopez state a pure crisis intervention model of social work practice fails to capture the special qualities of intervention with AIDS paitents. (Lopez & Getzel, 1984). A crisis situation is also described by N. Golan (1978) as consisting of a hazardous event, a vulnerable state, a precipitating factor, a state of active crisis, and a state of reintegration or crisis resolution. These definitions raise important issues for social workers or therapists counseling PWA's. To further define crisis situations, G. Caplan (1978) notes that a crisis occurs when a person faces an obstacle to important life goals that is, for a time, through the utilization of his customary methods of problem-solving. Both Caplan and Golan see crisis situations as self-limiting which

frequently prevents problem-solving on the part of the PWA. In feeling helpless, the PWA may then seek a therapist for individual counseling in an effort to somehow put their life in order.

Lopez and Getzel, both social workers who have counseled PWAs, state that because AIDS patients face the dual uncertainty of what specific health crisis will be encountered next and if they will die, neither the patient or the worker can honestly posit a stage of reintegration or restoration of equilibrium from a state of active crisis. (Lopez & Getzel, 1984). In addition to their emotional state, opportunistic infections may weaken a PWAs capacity to solve problems. As noted by Getzel and Lopez, loss of lucidity is quite common in AIDS, moreover, when the patient is lucid, his or her exhaustion and shock may severely limit the worker's activity with the patient. (Lopez & Getzel, 1984). When this happens the worker is caught in a powerful dilemma. On one hand, the authors state, supporting the patient in overcoming the immediate crisis that can be handled through problem-solving and provision of supportive services and, on the other hand, preparing patient for a death which may occur at any time. The balancing of these tacks, according to Lopez and Getzel, which connote

both hope and hopelessness within a tight time frame is the reciprocal burden for the patient and the worker. (Lopez & Getzel, 1984). Therefore it is very important for the worker to listen closely to what the PWA is saying. If he or she focuses on death and recognizes it is forthcoming, it is the workers responsibility to react appropriately and respond openly on the subject. This approach may not be easy for neither the PWA or therapist, it is often an issue in which the PWA is glad it was focused on.

Psychiatrists treating people with AIDS report that shock is almost the initial reaction, followed closely by denial, sometimes straight forward, other times quite elaborate, of the fact that they have a potentially fatal illness. (Hausman, 1986). At this stage, according to S. Nichols, M.D., a psychiatrist who has treated many AIDS patients, including gays and drug abusers, some patients impose total isolation on themselves, others express enormous amounts of anger and hostility, while others carry on business as usual, not acknowledging the changes that must be made in their lives. (Hausman, 1986). Hausman notes that at various and unpredictable times the patients go through periods of anger, resignation, fear, and extreme anxiety,

similar to the experiences of many terminally ill people, but often more extreme because no potentially successful treatment can as yet be offered and no one has yet to recover from the disease.

R. Schartz (1986) a psychiatrist in Washington, has observed more defined stages in his AIDS patients. He states that after the initial reaction to their illness most of the patients he has seen begin to realize the ways in which their lives are about to change and usually show a serious loss of control, becoming too frantic to make day-to-day decisions and use their traditional coping mechanisms. Not only do PWAs experience loss of control of their daily lives, they are often ostracized and estranged from family, friends, and society.

Schwartz (1986) states states the next emotional crisis arises out of their increasing isolation whether voluntary or involuntary. They are often treated like pariahs and are often forced to make so many decisions alone that the few coping skills still available to them are severely strained. And as the disease progresses, it is not unusual for serious depression to appear with many PWAs not eating, displaying suicidal ideations, and becoming obsessed with the daily changes they see or imagine they see in their bodies.

Guilt becomes the most underlining factor in AIDS patients according to many psychiatrists and social workers who treat them. For drug abusers who contract AIDS the issue of sexuality also cannot be avoided. Upon fearing they have a disease associated with gay men, may be the first time that those among them who are gay or bisexual as well as those who ever wrestled with homosexual feelings have been forced to confront their sexual identity, noted H. Rosenberg, M.S.W. They frequently respond with aggression when questioned about their sexual practices and vigorously deny any chance they may be gay, although for some there is evidence to the contrary. (Hausman, 1986).

Individual counseling with a PWA is very emotional, not only for the PWA but for the counselor as well. Dr. Barato (1983) a psychiatrist at the Memorial Sloan-Kettering Cancer Center sums up his experience in working with PWAs, especially those with Kaposis sarcoma (K.S.):

> As a psychiatrist at the Memorial Sloan-Kettering Cancer Center, I have the opportunity to interview, evaluate, and treat many patients with kaposis sarcoma and AIDS who are experiencing difficulties in coping with their illness. More

> than any other population of cancer patients, this one suffers a dramatic change in self-esteem, daily habits, and general life style in response to the onset of the illness. Psychological and social interventions are an integral part of treatment, for without adequate coping strategies and environmental supports, patients are easily lost from follow-up care. (p.63).

Counselors, social workers, and psychiatrists each have different approaches and different circumstances in which various counseling techniques warrant the way a PWA is receiving counseling, but K. Wein, Ph.D and D. Lopez, C.S.W. offer the best counseling recommendations as stated below by this author.

Support groups have become a vital part of the treatment of PWA. Mack (1986) states that groups allow for the enhancement of social support by providing clients with the opportunity to discuss issues and problems related to the illness with others who are experiencing similar problems. These groups are often the principal source of psychological support available to some PWA. As noted in Mack's (1986) article, a range of group modalities has been found to be useful for PWA, including cognitive-behavioral groups, therapy

groups, self-help groups, and groups for family members.

Patients who have just received a diagnosis of AIDS may find a support group too frightening an experience however, a more formal social setting may provide the structure needed for the patient to resist the tendency to remain isolated. (U.S. Department of Health & Human Services, 1986). Joining a group may be frightening but often, especially if the PWA is not in denial, it is a form of acceptance. According to Morin, Charles, and Malyon, attending the group means one accepts the diagnosis and is willing to confront in the words, faces, and physical conditions of the other group members what the future may bring. (Morin, Charles, & Maylon, 1984).

Counselors should spend an abundance of time preparing the PWA to enter or stay in a support group. According to the U.S. Department of Health and Human Services (1986) experience has shown that support groups should be open-ended, allowing PWA to attend intermittently if they choose. Information gained in the group may make it possible for them to dismiss untrue notions about AIDS. They can learn that, although they have every reason to feel sad, frightened, and angry, they can control their own attitudes, make

their own decisions, and within limits, manage their own lives. Many learn to participate more actively in their own treatment, contributing to treatment decisions and augmenting medical procedures with attention to diet, adequate rest, exercise, and relaxation.

Mack (1986) states that for many PWAs, group interventions are sufficient, for others, groups are useful in conjunction with individual treatment. It is therefore most effective to use individual therapy with support groups to effectively provide treatment to IV drug users with AIDS. Mack (1986) elaborates further in her article by stating clients should be encouraged or required to be in individual therapy while participating in a group if they are assessed to be at a high risk for psychological decompensation, have a characterological disorder or are actively suicidal.

In order to refer one to a support group, he or she must be assessed carefully. If a client, upon assessment seems he or she would not benefit from a support group, it should be upon the advice of the therapist to refer the PWA to a different treatment modality.

The physical contact in support groups is of great importance to PWAs, who may not get much physical comfort elsewhere due to people's unjustified and ill-informed

fears of casual contagion. (Morin, Charles, & Maylon, 1984). It is also noted by the above three authors that groups also help people express their anger and resentment as a result of having lost friends, lovers, and homes and at being asked to leave bars, restaurants and even juries. (Morin, Charles, & Maylon, 1984). Support groups cover topics from living with AIDS to dying with AIDS, and tears are openly shed and laughter is encouraged. Morin, Charles, and Maylon conclude from their experience with groups include practical considerations such as medical information, decisions about treatment, financial planning, disability applications, ways of responding to discriminatory treatment, and needs for supportive physical contact. (Morin, Charles, & Maylon, 1984).

There are basically two types of groups offered to PWAs according to Mack (1986) short-term closed groups and long-term groups. For persons facing a life-threatening illness, a short term closed group model can provide consistency, thereby enhancing the development of social support. Long-term groups offer the opportunity in-depth therapeutic intervention, they are difficult in this situation because of the increasing debilitation and frequent deaths of group

members. The major disadvantage to closed group models is the significant lag time that may occur between the client's initial contact with the group facilitator or agency and the beginning of the group.

Prevention and Treatment

Knowing the facts about AIDS can prevent the spread of the disease. According to the surgeon general, C.E. Koop (1986) and his report on AIDS, he instructed education of those who risk infecting themselves or infecting other people is the only way we can stop the spread of AIDS. Not only must people be responsible about their sexual behavior, the report continues, but responsible about their sexual behavior and must avoid the use of IV drugs and needle sharing. Koop (1986) concluded the AIDS virus infects persons who expose themselves to known risk behavior, such as certain types of homosexual and heterosexual activities or sharing IV drug equipment.

There is no vaccine for AIDS itself, however, there is good reason to believe that individuals can reduce their risk of becoming infected with the AIDS virus by observing precautions based on knowledge of how the virus is transmitted. (U.S. Department of Health & Human Services, 1986). The Department of Health and

Human Services (1986) also acknowledge that the communities can help prevent AIDS by educating and informing the population about the illness, with special emphasis on educating members of high risk groups.

The U.S. Department of Health Services recommends that the following steps be taken to prevent the spread of the AIDS virus for the general public:

1. Don't have sex with multiple partners or with persons who have had multiple partners (including prostitutes). The more partners you have, the greater your risk of contracting AIDS.
2. Obviously avoiding sex with persons with AIDS, members of risk groups, or persons who have had a positive result on the HTLV-III antibody test would eliminate the risk of sexually transmitted infection by the virus. However, if you do have sex with a person you think is infected, protect yourself by taking appropriate precautions to prevent contact with the person's body fluids.
   - Use condoms, which may reduce the possibility of transmitting the virus.

- Avoid practices that may injure body tissues (for example, anal intercourse).
- Avoid oral - genital contact
- Avoid open-mouth, intimate kissing
- Don't use IV drugs. If you do, don't share needles or syringes.

According to AID Atlanta, no treatment has yet been successful in restoring the immune system of an AIDS patient, although some physicians have had some success in using drugs, radiation and surgery to treat the various illnesses of PWA. (AID Atlanta, Facts About AIDS, 1986).

For example, pneumocystis carinii pneumona can be treated with antibiotics, a virus-fighting protein produced naturally by the body, and has been used with some success against kaposi sarcoma. (Facts About Aids, 1986).

Although there is no cure, an article featured in Time magazine confirmed that the FDA has approved the first therapeutic drug: azidothymidine (AZT), manufactured by Burroughs Wellcome. AZT, which has already been given to more than 3,000 AIDS patients, is a source of optimism to AIDS researchers. C. Wallis (1986) continues in her articles by stating, AZT not

only prolongs survival, but produces clinical improvements: weight gains, increased energy, neurological improvements. Not only does improvement occur, but it can reverse one of the most disturbing symptoms of advanced AIDS dementia and loss of mental functioning.

Unfortunately, AZT is not a cure and has a number of serious drawbacks, including toxicity, severe bone marrow damage and anemia. Approximately half of the patients on AZT will require weekly or bi-monthly blood transfusions. (Wallis, 1987).

Theoretical Framework

There appears to be a relationship between individual counseling and support groups and the ability to stop IV drug use with PWAs. If an IV drug user receives individual counseling, the less likely, he or she will continue the drug abuse, as found by (Fawzy, 1986; Macks, 1986; & Wilcott, 1986).

As stated by Mack (1986), individual therapy helps manage feelings and crisis and allows a PWA to become in control of his life and his decision making process. In addition to individual counseling a wide range of group modalities have been found to be helpful for the

PWA, including congitive-behavioral groups, therapy groups, self-help groups, and groups for family members.

In exploring theoretical perspectives the crisis theory best describes this framework. Crisis theory reflects a realistic struggle to deal with an individual's current life situation. (Turner, 1979). By looking at the PWA who abuses drugs he has two issues to deal with; a terminal illness and an addictive lifestyle. According to Turner (1979) during the unraveling of the crisis situation, the individual tends to be particularly amenable to help. Customary defense mechanisms have become weakened, usual coping patterns have proved inadequate, and the ego has become more open to outside influence and change.

Caplan explains that a crisis situation arises when functioning is interrupted. Feelings of helplessness may also result in the disorganization of function. Individuals in crisis appear to be less effective than usual, and the activities in which they engage may appear to be unrelated to the external situation. (Schuster & Ashburn, 1986).

According to Caplan, during a crisis situation the individual may pass through four phases:

1. A rise in tension, which calls for the bringing forth of problem-solving methods.
2. If these methods fail, the person will continue to evoke tension and disorganized functioning.
3. After assessing various resources, goals may be released, the situation redefined, and the problem solved.
4. If the situation continue or cannot be resolved, tension will mount which can result in anxiety and a disorganization of function that will result in emotional upset. (Schuster & Ashburn, 1986.

Psychiatrists treating people with AIDS report that shock is almost always the initial reaction, followed closely by denial. At this stage most PWAs express anger and hostility, while others carry on business as usual, not acknowledging the changes that must be made in their lives. At various times the patients go through periods of anger, resignation, fear, and severe anxiety. This is usually associated with the thought that no successful treatment can be offered and no one has yet to recover from AIDS.

As noted earlier by Schwartz (1986), a psychiatrist who works with PWAs finds that after the shock of the initial diagnosis, most patients show a loss of control, become frantic to make day-to-day decisions and lose use of their traditional coping mechanisms. At this point some type of treatment methodology is needed to help the PWA gain insight as to what major decisions are needed to help live a meaningful quality of life for the remainder of life. As the crisis intervention theory states, at this point two different treatments are needed' treatment aimed at maintaining and/or modifying adaptive patterns.

Siporin (1979) states, "A social worker's position in dealing with crisis situations has to be the development of short term interventions with a time limited model of focused treatment, with variety in a wide range of settings." Siporin states that when faced with excessive stress and crisis, and when needed resources are inadequate to the requirements of the tasks involved, people have difficulty in social functioning and have problems in social living; their coping abilities break down or are impaired. Most PWAs are able to regain equilibrium and to resume day-to-day

functioning when treatment (both medical and emotional) is restored.

In the assessment process, there is a focus on identifying the immediate specific difficulties in social functioning that people are having in their lives. In treatment methodologies, there should be an examination of coping capacities of individuals and groups, of situational hazards, obstacles, opportunities, and resources and of meanings and consequences of crisis precipitating events. (Golan, 1979). The intervention process in crisis intervention should emphasize brief, intensive helping activity for both groups and individuals.

If crisis intervention is to become a practice modality, it must be considered an important practice for all social workers. It should be used for long-term crises as well as short-term situations. Effective crisis intervention as noted by Golan (1979) requires training at three different levels.

1. Conceptual Skills; those skills that provide the framework for understanding problems, and developing strategies for change.

2. Clinical Skills; these skills are useful for implementing an effective therapeutic strategy, which are an extension of the conceptual framework.
3. Communication Skills; skills that are necessary to enhance information in a therapeutic relationship and to create a nonthreatening bond. (Golan, 1979).

Crisis therapy training can provide opportunities to learn to set limits, to negotiate goals, to focus on stress, to learn to make rapid assessments, to become more active and direct, and to gain experience in managing difficult patients, and to learn termination and disposition skills.

This then is the theoretical framework on which social work builds its explanation of crisis theory. It is also the framework which satisfies the explanation of this study of the effectiveness of treatment methodologies with PWAs.

Statement of the Hypotheses

For this study the following null hypotheses were developed:

$1H_o$: There is no significant relationship in the participation of support groups and the ability to stop drug abuse in IV drug users with the AIDS virus.

$2H_o$: There is no significant relationship between individual counseling and the ability to stop drug abuse in IV drug users with the AIDS virus.

Operational Definitions

The following definitions describe and define terms used in this study.

Acquired Immune Deficiency Syndrome (AIDS). An acquired defect in immune system function which reduces the affected person's resistance to certain types of infections and cancers. Although the cause is unknown for certain, it is thought to be a virus (HTLV-III) which is transmitted through sexual contact or exposure to infected blood or blood products.

AIDS-Related Complex (ARC). A variety of chronic symptoms and physical findings that occur in some persons who are infected with HIV but do not meet the CDC's definition of AIDS.

Body Fluids. Include blood, semen, urine, feces, saliva, and women's genital secretions.

Herpes Simplex Virus. The virus that results in cold sores or fever blisters on the mouth or around the eyes. Like all herpes viruses, the virus may be dormant for months, or years, in nerve or lymph tissue and flare up again under stress, trauma, infection, or immunosuppression.

High Risk Groups. Persons at increased risk of HTLV-III infection include: homosexual and bisexual men; present or past IV drug users; persons with clinical or laboratory ardence of infection, such as signs or symptoms compatible with AIDS or AIDS-related illnesses; persons born in countries where heterosexual transmission is thought to be a major role in the spreak of HTLV-III (for example, Haiti, and Central African countries); male or female prostitutes and their sex partners, sex partners of infected persons or persons at increased risk; persons with hemophilia who have received clotting factor products; and newborn infants of high-risk or infected mothers.

HIV(+) or Human Immunodeficiency Virus. The virus that causes AIDS.

Intravenous. Injected into or delivered through a needle in a vein.

Immune System. A complex network of specialized organs and cells that has evolved to defend the body against attacks by "foreign" invaders. When functioning properly, it fights off infections by agents such as bacteria and viruses.

Immunosuppressant. A state of the body where the immune system defenses do not work normally. This can be the result of illness or the administration of certain drugs.

Kaposi's Sarcoma (KS). A tumor of the walls of blood vessels. Usually appears as pink to purple, painless spots on the skin but may also occur internally in addition to or independent of the skin lesions.

Opportunistic Diseases. Those diseases that are caused by agents that are frequently present in our bodies or environment but which cause disease only when there is an alteration from normal healthy conditions, such as when the immune system becomes depressed.

Penumocystis Carinii Pneumonia (PCP). A lung infection seen in immunosuppressed people. It is caused by a protozoa present almost everywhere but which is normally destroyed by healthy immune systems. It is airborne.

Safe Sex. Using a condom when engaging in sexual intercourse. This applies to any sexual activity where body fluids are exchanged. This includes anal, vaginal, or oral intercourse.

CHAPTER III

METHODOLOGY

Research Design

The cross-sectional survey design was used in the collection of data to test whether there was a relationship between two or more quantifiable variables, individual counseling and support groups, and the ability to stop using drugs. The degree of relationship exists in the form of correlations coefficient.

The Sample

The sample consisted of 45 subjects who were clients of AID Atlanta and inmates who were incarcerated at Augusta Correctional Medical Institute (ACMI). All of these subjects were using or had previously used intravenous drugs, and all were infected with the AIDS virus. The sample was a non-randomized sample of convenience, as the subjects were taken from AID Atlanta's client case load whose primary and secondary risk factors of contracting the AIDS virus was intravenous drug use. The questionnaire was also distributed to inmates with the AIDS virus incarcerated

at ACMI. This sample was also a non-randomized sample of convenience, as those subjects were taken from two floors of the prison where all inmates infected with the AIDS virus are housed.

The Settings

AID Atlanta is a non-profit social service agency which was organized to respond to the AIDS epidemic. Direct services are offered to people with full-blown AIDS and ARC (AIDS related Complex) and education is provided to the community about the disease and its prevention. AID Atlanta offers its services to the metro Atlanta area and fifteen surrounding counties. Services are provided to anyone who has a Centers for Disease Control definition of AIDS or ARC, and are available to all who need them; without regard to age, race, sex, sexual orientation, economic class, physical limitations, and past or present addictive history.

Request for services for a person with AIDS or ARC must be made by the PWA, or by another person with the PWA's permission. All information is held in strictest confidence.

Services in the agency include: intake and needs assessment, individual counseling, buddies and practical support, transportation, support groups, meals on

wheels, housing, pastoral counseling, and an education department which provides an info-line and speaker's bureau trained to educate the community at large.

AID Atlanta is funded both publicly and privately. Public funds are provided by such organizations as: Health Resources and Services Administration (HRSA), the Georgia State Legislature, and Dekalb County. Private funds are from organizations such as the Robert Wood Johnson Foundation, Heartstrings, and other private persons and institutions. The agency has contractual agreements with Vocational Rehabilitation, Grady Hospice, Visiting Nurses Association, and the Infectious Disease Clinc at Grady Hospital. The agency is open from 9:00 a.m. to 9:00 p.m., Monday-Friday, but emergency calls are taken 24 hours a day on weekdays, weekends, and holidays.

Augusta Correctional Medical Institute (ACMI) is a minimum and maximum security institute located in Grovetown, Georgia. ACMI house over 700 inmates both male and female. The correctional facility has a medical unit on the premises in which surgery is performed on inmates throughout the State of Georgia. Inmates who test positive for the AIDS virus are

segregated from the rest of the prison population, and not allowed any contact with other inmates.

Services for these inmates include support groups and individual counseling. These services are facilitated by counselors employed by the prison system.

Instrumentation

In order to determine the impact of individual counseling and support groups on IV drug users with the AIDS virus, a questionnaire was developed by AID Atlanta and this researcher. The instrument used in this survey was a 30 item questionnaire. It included descriptive data about the subjects, e.g. age, sex, and specific questions regarding IV drug use, e.g. length of time using IV drugs, and number of times the subjects had been involved in individual counseling and support groups for their drug addiction. A copy of the instrument may be found in the appendix.

Data Analysis

For the purpose of this study, the data were analyzed using descriptive statistics and are reported in terms of frequency and percentage. The Phi (Ø) test was also used to determine the strength of the relationship between the ability to stop using drugs and individual counseling and support groups. The Phi statistic is a suitable measure of association, e.g. a

measure of strength of relationship. Phi (ø) makes a correction for the fact that the value of chi-square is directly proportional to the number of cases N by adjusting the X^2 value. Its formula is:

$$ø = \left(\frac{X^2}{N}\right)^{½}$$

Phi takes on the value of 0 when no relationship exists, and the value of +1 when the variables are perfectly related. (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975).

CHAPTER IV

PRESENTATION OF RESULTS

The data collected in the study provided a profile of the 45 subjects who participated in the survey. The hypothesis will be presented first so that the reader will have some interpretation of the major findings.

$1H_o$: There is no significant relationship in the participation of support groups and the ability to stop drug abuse in IV drug users with the AIDS virus.

To test for this null hypothesis, the cross tabulation was performed using the SPSSX batch system to determine the relationship between individual counseling and the ability to stop using drugs. The Phi (Ø) statistic was used to test for this hypothesis. The result of the contingency tables analysis shows Ø = 0.786, P 0.001 (see Table 1). Based on this result, we can determine that there is a strong relationship between support groups and the ability to stop using drugs.

Findings from the review of literature substantiate this conclusion.

Group interventions have been documented to be useful for persons facing life threatening illnesses.

Fawzy, 1985; Mack, 1986; & Wilcott, 1985, all conclude this in various studies they have conducted with people who facilitate support groups for PWAs. Studies also show that for people facing a life threatening illness, support groups can provide consistency, thereby developing social support between the group members.

The general attitude of most researchers is that there is some significant impact of support groups and the ability to stop using drugs, this determines whether or not the PWA will live the remainder of his life using IV drugs. Those PWAs who have not participated in support groups for their IV drug abuse, usually find it very difficult to curtail their drug usage. The theory is that, without the help of a support group, the PWA will continue to use drugs, despite an AIDS diagnosis.

Table 1

Cross Tabulation of Support Groups and the Ability to Stop Using Drugs

Participation in Support Groups	Yes	No
Yes	14 (73.7)	5 (26.3)
No	(0) (0)	26 (100)

Phi (Ø) = 0.786

P < 0.001

$2H_o$: There is no significant relationship between individual counseling and the ability to stop drug abuse in IV drug users with the AIDS virus.

To test this null hypothesis, the cross tabulation was performed using the SPSSX batch system to determine the relationship between individual counseling and the ability to stop drug abuse in IV drug users with the AIDS virus. The result of the statistical analysis shows: Phi (Ø) = 0.827, P 0.001 (see Table 2). Thus, we reject the null hypothesis and accept the research hypothesis that there is a significant relationship between individual counseling and the ability to stop drug abuse in IV drug users with the AIDS virus.

From these results, we can conclude that the nature of the relationship is strong.

According to the literature, individual therapy can be useful in addressing the PWAs' ability to manage feelings and crisis, enhance support systems, maintain hopefulness, and allow the PWAs to make the best of their decision making skills. This concludes that with the help of individual counseling, structure can be provided for the PWA to work through the stages of grief.

This gives some implications for the need of more understanding and theoretical knowledge in attempting to bring about change in these treatment methodologies when providing services to the IV drug user with the AIDS virus.

Table 2

Cross Tabulation of Individual Counseling and the Ability to Stop Using Drugs

Individual Counseling	Ability to Stop Using Drugs	
	Yes	No
Yes	15 (78.9)	4 (21.1)
No	0 (00)	26 (100)

Phi (Ø) = 0.827

$P < .001$

Demographic data from the findings included information from 45 subjects. Of the 45 participants, 26 (57 percent) were black, 12 (26 percent) were white and 7 (6 percent) were of other nationalities. Twenty-one (46 percent) were single, 17 (37 percent) were married, 3 (6 percent) were divorced, 3 (6 percent) were separated, and 1 (2 percent) was widowed.

In terms of age 23 (48 percent) were between the ages of 22 and 30, 21 (46 percent) were between the ages of 31 and 49, and 1 (4 percent) was between the ages of 16 and 21. Of all the subjects studied, 39 (86 percent) were male and 6 (13 percent) were female.

In the area of education, 24 (53 percent) had completed high school, 14 (31 percent) had completed some college, 4 (8 percent) had completed some high school, 2 (4 percent) had completed college, and 1 (2 percent) had received a graduate degree. Tables 3-7 summarizes the demographic data.

Table 3

Frequency and Percent of Respondents by Race

Race	Frequency	Percent
Black	26	57.8
White	12	26.7
Other	7	15.5
Total	45	100.0

Table 4

Frequency and Percent of Respondents by Marital Status

Marital Status	Frequency	Percent
Single	21	46.7
Married	17	37.8
Divorced	3	6.7
Separated	3	6.6
Widowed	1	2.2
Total	45	100.0

Table 5

Frequency and Percent of Respondents by Age Range

Age Range	Frequency	Percent
16-21	2	4.4
22-30	22	48.9
31-49	21	46.7
Total	45	100.0

Table 6

Frequency and Percent of Respondents by Sex

Sex	Frequency	Percent
Male	39	86.7
Female	6	13.3
Total	45	100.0

Table 7

Frequency and Percent of Respondents by Education

Education	Frequency	Percent
Some High School	4	8.9
High School Graduate	24	53.3
Some College	14	31.1
College Degree	2	4.4
Graduate Degree	1	2.3
Total	45	100.0

In terms of factors which led to use of IV drugs, 16 (35 percent) stated it was to maintain a certain emotional state, 13 (28 percent) stated it was experimental/curiosity, 10 (22 percent) stated it was recreational/social, and 6 (13 percent) stated it was peer pressure. Table 8 summarizes this information.

Table 8

Frequency and Percent Distribution of Factors Which Led to Use of IV Drugs

Factors Which Led To Use of IV Drugs	Frequency	Percent
Maintain Emotional State	16	35.6
Experimental/Curiosity	13	28.9
Recreational/Social	10	22.2
Peer Pressure	6	13.3
Total	45	100.0

Of all subjects studied, 24 (53 percent) had used drugs more than five years, 14 (31 percent) had used drugs three to six months, 2 (4 percent) had used drugs

one year or more, and 2 (4 percent) had used drugs two years or more.

Fourteen (31 percent) of the participants admitted using drugs daily or as often as possible; 12 (26 percent) admitted using drugs weekly, and 5 (11 percent) admitted using drugs about once a week.

In this study, most subjects admitted using other drugs in addition to IV drugs. Forty-two (93 percent) admitted using other drugs.

From the list of other drugs used 23 (51 percent) used heroin, 7 (15 percent) used alcohol, 6 (13 percent) used marijuana, 3 (6 percent) admitted using alcohol, marijuana, barbiturates, and heroin, and 2 (4 percent) used barbiturates and other drugs (this included ritland, codiene and dorien).

Concerning the method of administration, data revealed that the most frequent method of use was injection represented by 31 (68 percent), and 4 (8 percent) liked to smoke and snort their drugs.

Thirty-one (68 percent) subjects responded that they used IV drugs alone, while 3 (6 percent) stated they did not.

In terms of actual cost, 22 (48 percent) had spent $500 or more in one day on IV drugs, 6 (13 percent)

had spent $200-$300, 4 (8 percent) had spent $50 or less, 4 (8 percent) had spent $100, and 3(6 percent) had spent $400 in one day on IV drugs. Table 9 summarizes the amount of money respondents spent on drugs in one day.

Table 9

Frequency Distribution of Amount Spent on Drugs

Amount of Money Spent on Drugs	Frequency	Percent
$50 or less	4	8.9
100	4	8.9
200	6	13.3
300	6	13.3
400	3	6.7
500 or more	22	48.9
Total	45	100.0

There was an even distribution of responses in considering IV drug use a problem by the subjects. Nine (20 percent) responded in each category.

Almost half of the subjects 21 (46 percent) have sought treatment one to three times to stop their drug abuse; 13 (28 percent) have never sought treatment, 8 (17 percent) have sought treatment four to six times, 2 (4 percent) sought treatment seven to ten times, 1 (2 percent) sought treatment 11 times or more. Table 10 represents a summation of the number of times treatment was sought.

Table 10

Frequency and Percent of Number of Times Treatment Sought

Number of Times Treatment Sought	Frequency	Percent
1- 3 times	21	46.7
Never	13	28.9
4- 6 times	8	17.8
7-10 times	2	4.4
11 times or more	1	2.2
Total	45	100.0

It appears that the majority of the subjects studied sought treatment, not of their own accord, but

with some type of outside influences. Fourteen (38 percent) sought treatment because of a court order or jail sentence, 7 (20 percent) because they felt drugs were taking control of their lives, 6 (18 percent) because of family or spouse, 3 (14 percent) for different or other reasons, and 2 (9 percent) because of financial problems.

Nineteen (42 percent) of the subjects studied stated the treatment program helped somewhat, 11 (24 percent) stated the treatment program helped a great deal, and 2 (4 percent) stated the treatment program did not help at all. Table 11 shows those participants who sought the help of a treatment program, and how successful the intervention proved to be.

Table 11

Frequency and Percent Distribution of Benefits of Treatment Program

Benefits of Treatment	Frequency	Percent
Helped a Great Deal	19	42.2
Provide No Help	11	24.4
Helped Somewhat	2	4.4
Total	32	71.0

Table 12

Frequency Distribution of Respondents Involved With Narcotics Anonymous

Involved With Narcotics Anonymous	Frequency	Percent
Yes	20	44.4
No	19	42.4
Total	39	86.8

Thirteen (28 percent) had been involved with Narcotics Anonymous for three to six months, 10 (22 percent) had been involved for one to two years, 1 (2 percent) had been involved for three to five years and five years or more. Table 13 shows the number of participants involved in a support group at the present time.

Thirteen (28 percent) stated the support group helped a great deal, 8 (17 percent) stated the support group helped somewhat, and 3 (6 percent) stated the support group was of no help at all.

The majority of the subjects studied had never enrolled in a detoxification center. Twenty-nine

Table 13

Frequency and Percent of Respondents Currently Involved in a Support Group

Involved in a Support Group	Frequency	Percent
No	20	44.4
Yes	19	42.4
Total	39	86.8

(64 percent) had not and fifteen (33 percent) had enrolled.

Of those enrolled in a detoxification center, 8 (18 percent) stated it was helpful, and 7 (17 percent) stated it had not been helpful.

In this study, 30 (66 percent) had never received individual counseling, and 14 (31 percent) had received individual counseling. The following table 14 represents this data.

Of those who have received individual counseling 6 (13 percent) stated it helped somewhat and 4 (8 percent) of the subjects studied stated it was little or no help and the same number of respondents stated it was of great help.

Table 14

Frequency and Percent of Respondents Who Received Individual Counseling

Respondents Who Received Individual Counseling	Frequency	Percent
No	30	66.7
Yes	14	31.1
Total	44	98.8

In the past five years, 22 (48 percent) of the subjects studied had 1-20 sexual partners, 13 (28 percent) had 101 and above sexual partners, 6 (13 percent) had 20-40 sexual partners, 2 (4 percent) had 41-60 sexual partners. There were no respondents who scored in the 61-100 group. Table 15 shows that the majority of the subjects studied had been sexually active in the past five years.

Since being diagnosed with AIDS, 31 (66 percent) of the subjects studied have stopped using drugs, 9 (20 percent) use the same amount as before diagnosis, 3 (8 percent) use occassionally, and 1 (2 percent) use more drugs because of their diagnosis.

Table 15

Frequency and Percent Distribution of Sexual Partners in the Past Five Years

Number of Sexual Partners	Frequency	Percent
1-20	22	48.9
21-40	6	13.3
41-60	2	4.4
101 and above	13	28.9
Total	43	95.5

Twenty-two (48 percent) of the participants surveyed stated they will never use drugs again, 18 (33 percent) stated they will use drugs again, and 5 (11 percent) of the subjects at the time of the survey did not know whether they would use drugs again.

Since being diagnosed with the AIDS virus, 27 (60 percent) of the subjects stated their families are somewhat supportive, and 18 (40 percent) stated their families have been very supportive. Of all subjects studied no one admitted to the family being non-supportive.

CHAPTER V

IMPLICATIONS OF THE STUDY FOR SOCIAL WORK PRACTICE

The purpose of this study was to determine whether individual counseling and support groups are effective with IV drug users with the AIDS virus. Research from the literature review and the findings conclude that with the help of the above treatment methodologies, PWAs will be able to curtail their use of IV drugs.

With an AIDS diagnosis many PWAs face crisis situations, feelings of despair and anxiety, financial difficulties, and problems too numerous to mention. The onset of these problems, along with a "death sentence" forces many PWAs to lose control of their lives. With the opportunity to obtain individual counseling and support groups, the PWA will be able to maintain stability in his life by using the best of his coping mechanisms.

Conclusions from the hypotheses were as follows:

Hypothesis One

The first hypothesis predicted that there was no significant relationship in the participation of support groups and the ability to stop drug abuse in IV drug users with the AIDS virus. This hypothesis was rejected. There is a strong relationship between support groups and the ability to stop using drugs.

The findings from the review of literature agreed with this hypothesis. Group interventions have been documented to provide continuity therefore providing PWAs with support between the group members. PWAs can come together and share similar or different crisis situations they are experiencing. This in turn allows the group members to become aware of they are not fighting this epidemic alone.

Hypothesis Two

The second hypothesis predicted that there was no significant relationship between individual counseling and the ability to stop drug abuse in IV drug users with the AIDS virus. This hypothesis was also rejected.

The results concluded the relationship between the two treatment methodologies were quite strong.

According to the review of literature individual counseling can be useful in helping the PWA manage

crisis situations. This allows the PWA to utilize the best decision making skills.

By looking at the ratio of males to females studied, 38 males, six females, the researcher had anticipated a wider margin of females so that both sexes could be studied evenly. Also, this researcher anticipated studying more minorities in an effort to explore the Centers for Disease Control statistics that more minorities are IV drug users infected with the AIDS virus. The sample size, however, may have some bearing on the study findings.

Most subjects studied had been IV drug users for extensive periods of time, using drugs as often as possible which can also be equated to daily use. Even though the majority of participants studied used many different drugs, heroin was the most frequent drug used. The most frequent method of administration included injecting the drugs intravenously, followed by snorting and smoking. Even though most IV drug users preferred to use drugs with other people, most would not hesitate to use drugs alone.

Many of the respondents admitted their drug use has been a problem, although few had received individual counseling. As noted by this researcher, this shows the

lack of available opportunities to receive individual counseling. This is especially prevalent in drug users who are indigent.

In the past five years, 28 percent of the subjects admitted having sex with over 100 partners. This gives thought to the researcher of whether or not the IV drug user with the AIDS virus contracted the virus through IV drug use or sexual contact. Additionally, this researcher questions how many people may have been affected by the subjects studied.

The data collected in this study, despite the limitations, leaves the need for more treatment methodologies implemented by social workers in clinical and research practice.

Limitations of the Study

This study was limited to two agencies, AID Atlanta and Augusta Correctional Medical Institute (ACMI). Both agencies provide individual counseling and support groups, although the treatment methodologies are not identical. AID Atlanta's support groups and individual counseling services are more structured than those at ACMI. Further limitations include the small sample size and self reported data.

Implications for Social Workers

A theory is a way of explaining a specific phenomenon and/or behavior. It is based on known facts formulated into a system that can be used to predict other phenomenon or behavior. A workable theory of treatment methodologies would be very useful to persons in the field of social work. It would be particularly helpful in designing programs and strategies to better serve PWAs who use or have used IV drugs. This has various implications for social workers who work closely with these clients as well as those social workers in other areas of social work who encounter the issues of drug abuse, facilitating support groups such as Narcotics Anonymous (NA) and individual counseling.

There is a need for social workers to first become aware of the AIDS epidemic. Many social workers are somewhat hesitant to work with such a new population. But what most fail to understand, is that the AIDS epidemic is becoming so prevalent, it is quite reasonable to state that any major problem facing the world today (e.g. homelessness, drug abuse, teenage pregnancy, and mental illness), AIDS, if not at this time, will be associated with them. The problem solving method should be utilized by first acknowledging that

the AIDS epidemic is a major problem and must be addressed by social workers. This can be done through education in schools, communities, and cities. It should start with our youth and end with senior citizens. Education should entail transmission of the virus, prevention, sex education, the course of the disease and its devastating effects. This illustrates a need for social workers to initiate these services in attempting to control the spread of the AIDS virus.

The same ideas apply to social workers to become aware of the widespread drug problem. The system does not provide the "realistic" drug prevention programs needed to curtail drug use. Here, the social worker has the role of being an advocate for the drug abuse problem by implementing programs for additional detoxification centers. This may entail writing grant proposals, writing to city and state governmental officials, for money in building additional detoxification centers, and making communities aware of the drug problem.

Drug abuse is not only a problem of those found at the lowest socioeconomic level, but is also found in middle and upper class families. There is a need, especially for parents, to instill in their children

the effects of drug abuse and the risks, both physically and mentally. A strong bond among family members, in addition to community recreational facilities, are needed to provide positive role models and extracurricular activities for youths who are faced with the temptation of experimenting with drugs.

In working with drug addiction, most resources available require medical insurance. The majority of drug abusers do not have medical insurance nor legitimate jobs. Therefore, they are dependent on city and state facilities for support groups and individual counseling that is needed.

There is a growing need for social workers to become aware and have a clear understanding of the AIDS epidemic. Furthermore, additional knowledge is needed for effective treatment methods for drug abusers. Many of the social issues that social workers are currently working with have been found to be determinants of drug abuse. With a clear understanding of drug abuse and how it is affecting an entire nation, the social worker is better able to provide the necessary services and programs in an attempt to bring about better treatment services and availability to drug abusers, especially those who have been infected with the AIDS virus.

With the growing number of people with the AIDS virus who are drug abusers, further research is needed in studying the causative factors of drug abuse. It is suggested that in conducting further research, a larger population of people with AIDS who are drug users be interviewed, to give a more accurate perception of the problem. More variables need to be tested such as self-esteem, how PWAs with the AIDS virus are perceiving their diagnosis, financial status, etc. . . This information would provide further understanding in the causation of drug abuse especially in those persons with AIDS, and ways in which social workers could better provide services to this special population as well as initiate effective preventive techniques.

REFERENCES

Aids: The African myth exposed. (1988, January-February). African Heritage.

Aids workers plan anonymous testing at variety of clinics. (6 March 1987). The New York Times.

American Red Cross. (1986, October). U.S. Public Health Service manual.

Batki, et. al. (1988, April). Psychiatric aspects of Treatment of IV drug abusers with aids. Hospital and Community Psychiatry, 39, 439.

Buckingham, & Van Gorp. (1988, March-April). Essential knowledge about aids dementia. Social Work, 33, 112.

Caitlin, R.C. (1987). Statement of the challenge. In Responding to aids: Psycho-social initiatives. NASW.

Centers for Disease Control. (1985 & 1986). Atlanta, Georgia.

Centers for Disease Control. (1986). Weekly Surveillance.

Coolfront Report: A PHS plan for prevention and control of aids and the aids virus. (1986, August). Public Health Reports, 101, 348.

Hidalgo, H., Peterson, T., & Woodman, N. (1985). Lesbian and gay issues: A resource manual for social workers. Silver Springs Maryland: NASW.

Johnson, V. (1980). I'll quit tomorrow. San Francisco: Harper & Row.

Kreiger, T., & Caceres, C.A. (1985, 21 October). The unnoticed link in aids cases. The Wall Street Journal.

Martelli, L.J., Peltz, F.D., & Messina, W. (1987). When someone you know has aids: A practical guide. New York: Crown Publishers, Inc.

McKusick, L. (1986). What to do about aids. Los Angeles, California: University of California Press.

New York Daily News. (11 October 1987).

Perry, & Markowitz. (1986, October). Psychotherapeutic interventions for aids-spectrum disorders. Hospital and Community Psychiatry, 37, 1001.

Population Reports. (1986, July & August).

Schuster, C.S., & Ashburn, S.S. (1986). The process of human development. Washington, D.C.: Library of Congress.

The Harris County Medical Society and The Houston Academy of Medicine. (1987). Aids: A guide for survival.

Taulstich, M. (1987, May). Psychiatric aspects of aids. The American Journal of Psychiatry, 144, 551.

Turner, F.J. (1979). Social work treatment. New York: Macmillian .

U.S. Department of Health and Human Services. (1986, Winter).

U.S. Department of Health and Human Services. (1986). Surgeon general's report on acquired immune deficiency syndrome. Washington, D.C.

U.S. Department of Health and Human Services. (1986). Coping with aids: Psychological and social considerations in helping people with HTLV-III infection. Washington, D.C.

APPENDIX

QUESTIONNAIRE

Hello,

I am an Atlanta University graduate student pursuing a Master's Degree in Social Work. I am conducting a study on treatment methods with I.V. drug users with the AIDS virus.

It would be helpful if you would answer some questions about the treatment you have been receiving since being diagnosed with the AIDS virus.

All the information is confidential, and will be used only to explore treatment methods used for I.V. drug users with the AIDS virus. Your identity will not be revealed; I do not need your name or any other identifying information.

Participation in this study is strictly voluntary and you do not have to answer any question you may feel uncomfortable about. The more information you provide the better I will be able to determine the treatment you have received.

Thank you for your time and cooperation.

Sincerely,

Sandra Goodman

SG/jr
enclosure

Questionnaire

Please check only one answer per question.

1. What led to your use of I.V. drugs?
   __recreational/social
   __peer pressure
   __experimental/curiosity
   __to maintain certain emotional state (to forget about certain problems)

2. For what period of time did you use I.V. drugs?
   __3-6 months
   __1 year or more
   __2 years or more
   __3-5 years
   __5 years or more

3. How often did you use I.V. drugs?
   __daily
   __weekly
   __monthly
   __as often as possible

4. Have you ever used any other drugs?
   __Yes
   __No

5. If yes, what other drugs did you use?
   __alcohol
   __marijuana
   __barbiturates
   __heroin or other narcotics
   __other (specify_____)
   __all of the above

6. Which of the following was your most frequent method of use?
   __smoke
   __snort
   __inject intravenously

7. Did you mainly use I.V. drugs with other people?
   __Yes
   __No

8. Did you ever use I.V. drugs alone?
   __Yes
   __No

9. What was the highest amount you spent on drugs in one day?
   __$50.00
   __$100.00
   __$200.00
   __$300.00
   __$400.00
   __$500.00 or more

10. When did you consider I.V. drug use a problem?
__dont't consider a problem
__1-6 months ago
__1 year ago
__2 years ago
__5 years or more ago

11. How many times have you sought treatment to stop your drug abuse?
__1-3 times
__4-6 times
__7-10 times
__11 times or more
__never

12. What made you seek treatment?
__family, spouse
__financial problems
__court order/jail sentence
__feelings that drugs were taking control of your life
__other (specify_____)

13. Did the treatment program help?
__provided no help at all
__helped somewhat
__helped a great deal

14. Have you ever been involved with Narcotics Anonymous?
__Yes
__No

15. If yes, how long?
__3-6 months
__1-2 years
__3-5 years
__5 years or more

16. Are you involved in a support group now?
__Yes
__No

17. If yes, is this helpful in your attempt to stop using drugs?
__little or no help
__helps somewhat
__helps a great deal
__no help at all

18. Have you ever enrolled in a detoxification center?
__Yes
__No

19. If yes, was this helpful in your attempt to stop using drugs?
__Yes
__No

20. Have you ever received individual counseling to stop your drug abuse?
__Yes
__No

21. If yes, has this been helpful in your attempt to stop your drug abuse?
__little or no help
__helps somewhat
__helps a great deal
__no help at all

22. In the past five years, how many sexual partners have you had?

_____

23. Since being diagnosed with the AIDS virus, have you?
__stopped using drugs completely
__use drugs occasionally
__use when depressed or on social occasions
__use the same amount of drugs as before diagnosis
__begun to use more drugs

24. Do you think you will ever use drugs again?
__Yes
__No
__Don't know

25. Since an AIDS diagnosis, how supportive is your family?
__very supportive
__somewhat supportive
__not supportive at all

26. Race
__white
__black
__hispanic
__other (specify_____)

27. Marital status
__single
__married
__widowed
__divorced
__separated

28. Age
__16-21
__22-30
__31-49
__50-65
__65 and over

29. Sex
__male
__female

30. Education

__completed some high school
__high school diploma
__completed some college
__college degree
__completed some graduate school
__graduate degree